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Recovery from depression:  
a systematic review of perceptions and associated factors

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## Recovery from depression: a systematic review of perceptions and associated factors

*Background:* Despite extensive literature examining perceptions of recovery from severe mental illness, literature focusing on recovery from depression in adults is limited.

*Aim:* Systematically review the existing literature investigating patients' and clinicians' perceptions of, and factors associated with, recovery from depression.

*Method:* Studies investigating perceptions of, and factors associated with, recovery from depression in adults were identified through database searches. Studies were assessed against inclusion criteria and quality rating checklists.

*Results:* Fourteen studies met the inclusion criteria. Recovery from depression is perceived as a complex, personal journey. The concept of normalised, biomedical definitions of recovery is not supported, with construction of self and societal gender expectations identified by women as central to recovery. Recovery from depression was associated with higher levels of perceived social support and group memberships. A range of factors are identified as influencing recovery. However, physicians and patients prioritise different factors assessing what is important in being 'cured' from depression.

*Conclusions:* Recovery from depression is perceived by patients as a complex, personal process, influenced by a range of factors. However, greater understanding of clinicians' perceptions of client recovery from depression is essential to inform clinical practice and influence future research.

*Declaration of interest:* None to declare.

## Recovery

The concept of recovery within mental health has received considerable attention in the past decade as manifested in key reviews (Bonney & Stickley, 2008; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Warner, 2009), position statements by professional groups (e.g., South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010), and the establishment in 2009 of Implementing Recovery through Organisational Change (ImROC; Shepherd, Boardman, & Burns, 2010). However, the concept of recovery itself has led to multiple definitions of the term (Bonney & Stickley, 2008). Whilst the recovery model itself emphasises concepts such as hope, meaning and sense of self (Dickens, 2009), up to 16 core elements of recovery have been identified (Onken et al., 2007). Furthermore, Slade (2012) distinguishes between clinical recovery and personal recovery. He proposes that clinical recovery focuses on professional imperatives, whilst personal recovery is more ideological and focuses on connectedness and social support, hope and optimism, identity, meaning and purpose, and empowerment (CHIME; Leamy et al., 2011).

While these elements of recovery are not specific to any single diagnostic group, the literature has tended to focus on people with lived experience of severe mental illness such as schizophrenia, bipolar, or psychosis rather than depression (Bonney & Stickley, 2008; Warner, 2009). Indeed, the themes encompassed by CHIME would appear to be equally relevant to people with lived experience of depression. However, a key review of the recovery literature identified 97 articles but found only three studies focusing on depression, each of which failed to reach the

quality threshold (Leamy et al., 2011). Similarly, factors found to hinder recovery from mental health difficulties – including social exclusion, discrimination, inaccessibility to work, and economic hardship (Coleman, 1999; Sayce, 2000) – might also hinder patients' recovery from depression.

One possibility as to why depression may be viewed differently could be the over association of depression with primary care services as set out in the National Institute for Health and Care Excellence (NICE) guideline for depression (NICE; 2009). In the UK, an earlier version of this guideline also informed the government's Improving Access to Psychological Therapies (IAPT, Layard, 2006) programme. In turn, this has led to the adoption of *recovery* (or *moving to recovery*) becoming associated with statistical definitions of recovery (as determined by obtaining a defined score on a specified symptom measure of depression). However, a retrospective review of the literature underpinning the NICE Guidelines for Depression has been carried out (McPherson, Evans, & Richardson, 2009). Of the 49 studies used as the evidence base in the NICE guidance, only 12 employed measures tapping quality of life or functioning, and while these measures were sensitive to change, they did not reveal the same superiority for cognitive behaviour therapy as yielded by symptomatic measures. Hence, it would appear that when more recovery-focused measures are implemented for depression, aspects of this clinical presentation are more enduring and debilitating. Indeed, one of the clinical features of depression is its chronicity and high rate of relapse.

Accordingly, the question of whether recovery from depression is distinct from recovery from other severe mental illnesses remains unanswered within the existing

literature. The aim of the present article is to systematically review the literature pertaining to perceptions of recovery from depression.

### **Depression: Definition, prevalence and burden**

Depression is a mood disorder characterised by persistent feelings of sadness, hopelessness, and a loss of interest in previously enjoyed activities. For a diagnosis of major depressive disorder (MDD), the Diagnostic and Statistical Manual (DSM) of Mental Disorders (DSM-5; American Psychiatric Association, 2013) requires the presence of depressed mood or a loss of interest or pleasure in daily activities for more than two weeks. The depressed mood must represent a change from the individual's baseline, resulting in impaired functioning. Presence of five (minimum) out of nine specific symptoms is also required, nearly every day.

Recent global prevalence estimates indicate that approximately 98.7 million people worldwide are affected by depression. Lifetime prevalence estimates for depression vary from 8-12% of the adult population (Ustun et al., 2004), with 12-month prevalence estimates ranging between 3% and 6% (Judd & Akiskal, 2000). Epidemiological research using data from six European countries also indicates greater prevalence of depression amongst women (8.75%) than men (5.01%), with marked gender differences for MDD persisting across all age groups (Angst et al., 2002).

Research published by the World Health Organisation (WHO) has identified depression as the leading cause of disability, with a 50% greater burden of depression for females than males (WHO, 2008). Associations between depression and physical health have also been demonstrated, with depression having more damaging long-term effects on health and well-being than angina, arthritis, asthma,

and diabetes (Moussavi et al., 2008). The economic burden of depression in England alone was estimated at £9bn in 2000 (Thomas & Morris, 2003), compared with estimated economic burdens of schizophrenia of £6.7bn (Mangalore & Knapp, 2007), and bipolar disorder of £2.1bn (Das Gupta & Guest, 2002).

### **Depression rating scales**

A range of depression rating scales exist to establish the presence of depression and provide an indication of depression severity. These scales can be completed by researchers, clinicians and/or patients. For example, the Hamilton Depression Rating Scale (Hamilton, 1967; 1986) is a 21-item scale completed by clinicians, who select appropriate responses after interviewing patients and observing their symptoms. In comparison, the Beck Depression Inventory (Beck et al., 1961) and the Centre for Epidemiologic Studies-Depression Scale (Radloff, 1977) are self-report inventories that cover a range of biological and affective symptoms of depression. The scales are completed by patients to identify the presence and severity of symptoms consistent with DSM diagnostic criteria for depression. Depression rating scales can be used to monitor the effects of both psychological and pharmacological treatments.

### **Aims of present review**

The present review aimed to synthesise the existing literature investigating patients' and clinicians' perceptions of, and factors associated with, recovery from depression in adults. As existing literature has indicated a greater incidence of depression amongst women than men, and identified social exclusion as a factor hindering recovery from mental illness, this paper systematically reviewed the available literature in order to:

- 1) Examine whether perceptions of recovery from depression differ according to gender.
- 2) Investigate the impact of perceived social support on recovery from depression.
- 3) Examine patients' and clinicians' perspectives of recovery from depression and factors associated with recovery.

## **Method**

### **Search strategy**

Searches of the following databases were conducted (all years to 23<sup>rd</sup> September 2015): Cochrane Library; MEDLINE, PsycARTICLES; PsycINFO; Pubmed; ScienceDirect; Scopus; and Web of Knowledge. The Boolean operator “AND” was used to search combinations of the following search terms: (i) defin\*, defining, definition; (ii) depression, depress\*; (iii) perception, perspective, view; and (iv) cure\*, recov\*, recovered, recovery.

In addition to the database searches of full texts, abstracts, and titles, the reference lists of full-text articles assessed for eligibility were also searched to identify any relevant studies that were not identified through database searches.

### **Inclusion/exclusion criteria**

Research papers written in English, published in peer-reviewed journals, and with a focus on depression in adults aged 18+ were included. Records were excluded if they focused on any of the following criteria without additional focus on perceptions of recovery from depression: (i) cognitive/biological processes involved in depression; (ii) clinical definitions of recovery; (iii) duration of recovery; (iv) explanations of recovery; (v) financial costs associated with depression; (vi)



measurement of depression; (vii) nature of depression; (viii) recovery as a peripheral topic; (ix) treatment of depression only; and (x) non-research paper.

### **Screening and selection**

Figure 1 illustrates the search process. After initial database searches, 1737 records were identified, of which 1682 were excluded on the basis of title. Primary evaluation of 55 abstracts and titles led to a further eight records being removed on the basis of duplication. Manual searching of reference lists identified three records for inclusion in assessment for eligibility, bringing the total number of full-text articles assessed for eligibility to 50. Following assessment for eligibility, 36 papers were excluded on the basis of not meeting the inclusion criteria, yielding 14 studies for further analysis.

*Insert Figure 1*

### **Quality appraisal**

The first author (KR) assessed the 14 studies identified as meeting the inclusion criteria against quality control checklists (see Table 1). The QualSyst checklists (Kmet et al., 2004) were used to assess the methodological quality of the studies, as items contained in the checklists emphasise internal study validity (Kmet et al., 2004). The quality assessment was made focusing on the methods important for this review.

**Quality appraisal of quantitative studies.** Quantitative studies are assessed using 14 criteria, with a total possible sum of 28 points available. A total sum score is calculated by allocating scores of two points for each criterion that is met and one point for partially met criteria. For nine criteria, there is an option of 'not applicable'. A

total possible sum is then calculated by multiplying the number of 'not applicable' criteria by two and subtracting the result from 28. The summary score is then calculated by dividing the total sum by the total possible sum.

**Quality appraisal of qualitative studies.** Qualitative studies are assessed using ten criteria, with a total possible sum of 20 points available. A total sum score is calculated by allocating scores of two points for each criterion that is met and one point for partially met criteria. The total sum is then divided by 20 to obtain a summary score.

**Independent verification of quality ratings.** Three papers were selected at random to be rated by an independent assessor, who was a postgraduate in social sciences. Inter-rater reliability was good (Kappa = .79,  $p = .001$ ; Peat, 2002), with discrepancies in scoring discussed until agreement was reached. The QualSyst assessment criteria recommend the exclusion of papers obtaining a quality rating score that is  $<.75$  of the total possible score.

*Insert Table 1.*

## Results

Table 2 summarises the key findings from reviewed studies. Results are presented in accordance with the review's aims, following three main themes: (i) recovery and gender; (ii) social support; and (iii) patient and clinician perspectives.

### Critique of papers

As indicated in Table 1, the papers included in the review were all assessed as having at least moderate quality. However, quality ratings varied from .75 (Fullagar & O'Brien, 2014; Johnson et al., 2009) to .95 (Vidler, 2005). Stronger papers were characterised by robust study designs, inclusion of detailed participant

characteristics, use of well-defined outcome measures, appropriate sample sizes, and drew conclusions that were supported by results. Stronger qualitative papers used verification procedures to establish credibility, and contained researchers' reflections on the impact that their own personal characteristics might have had on the data obtained. Weaker papers lacked verification procedures and reflexivity (qualitative papers), and had less robust study designs.

*Insert Table 2.*

### **Recovery and gender**

Five papers used qualitative research methods to investigate the perceptions of recovery held predominantly by women, with only one study investigating the perceptions of recovery held by men (Emslie et al., 2005). An overall total of 121 participants, 13.2% male and 86.8% female, participated in the included studies. Participants' ages ranged from 22 to 75 years. Only one study (Vidler, 2005) used measures in addition to researcher-developed semi-structured interview schedules.

Departure from normalised, symptom-focused perceptions of recovery was a theme across all five studies. Schreiber (1996) presented a model of recovery, (re)defining the self, which considers the individual women and the social contexts in which they are situated. Recovery from depression – or (re)defining the self - is defined as a social psychological process consisting of six phases: 1) my self before encountering depression; 2) seeing the abyss (confronting depression); 3) telling my story and 4) seeking understanding (two parallel processes); 5) cluing in (to facilitate understanding of the self and the world); and 6) seeing with clarity (accepting the depression journey, acknowledging vulnerabilities and developing compassion).

Schreiber emphasises that recovery is a personal journey, and that the final phase can take women years to reach.

In contrast to Schreiber's model, O'Brien (2012) found women's efforts to understand themselves and the world both impeded recovery and contributed to their depression. Furthermore, whilst Schreiber's model implies a linear recovery trajectory, O'Brien argues that attempts to follow linear, normalised recovery pathways leave women unable to maintain the trajectory that will lead to recovery, whilst relapses back into depression create a perpetual struggle to move towards normative concepts of recovery. O'Brien's research identified a sense of responsibility amongst women to undertake work to 'fix' their depression, and an expectation that recovery meant a return to previous normal functioning. Women's inability to return to previous normal functioning was interpreted as failure to recover, compounded by societal gender expectations. O'Brien concludes that the recovery imperative places an additional burden on women's expectations of themselves, whilst social constructions of gender both create women's depression and impede their recovery.

Associations between societal gender expectations and recovery from depression were also identified by Vidler (2005). Women's experiences of depression were found to be associated with continual interactions between the 'self' and 'other/s'. When these interactions occurred within the context of societal gender expectations that women would engage in self-sacrificing and self-silencing behaviours, depression developed. Recovery from depression was facilitated by women rebalancing their focus of care away from others and onto themselves, by attending to their own needs as opposed to the needs of others. Vidler also found

that all but one of the women who had recovered from depression were also no longer in intimate relationships, increasing their self-agency and ability to engage in self-care practices.

Fullagar and O'Brien (2014) also found that societal gender expectations were associated with 'normalised recovery', whereby recovery from depression would return women to "productive roles at home and work" (p.119). Women's perceptions of recovery were found to contrast with societal perceptions of recovery as a straightforward process, whereby symptoms are reduced through medication and 'normal' functioning resumes. Consistent with Vidler's (2005) findings, Fullagar and O'Brien also identified associations between women's ability to engage in self-care practices and recovery from depression, emphasising the role of self-agency and ability to take control of one's life. Recovery was also found to be a "complex process that involved translating emotions, multiple meanings and gender expectations about oneself as a woman at mid-life" (p.121). By redefining recovery beyond normalised, biomedical definitions, women were able to develop knowledge about themselves and identify self-care activities that helped shift their self-perception from 'deficient' to caring for oneself and meeting one's own emotional needs. As such, Fullagar and O'Brien argue that perceptions of recovery should shift from deficit models to viewing recovery as a social practice, whereby women realise opportunities to embody different 'beings and doings' through self-care.

Only one study explored men's perspectives of recovery from depression (Emslie et al., 2005). Consistent with the studies described above, construction of self was identified as central to recovery. However, men placed importance on reconstructing a valued sense of themselves and their own masculinity that

embraced socially constructed gender identities. Men's recovery from depression was facilitated through incorporation of values associated with hegemonic masculinity (those emphasising control, strength and responsibility to others) into rich narratives. However, the pressures of conforming to gender expectations were associated with suicidal behaviour in a minority, who perceived suicide as either courageous or the ultimate means of establishing control, consistent with gender expectations.

### *Summary of theme*

As only one study examined men's perceptions of recovery, the following conclusions relate only to women's perceptions of recovery. In summary, women perceive recovery from depression as a complex, personal journey. The concept of normalised, biomedical definitions of recovery is rejected, and associations between attempting to meet normative concepts of recovery and relapsing into depression are acknowledged. Construction of self and societal gender expectations are considered central features of recovery. Furthermore, women described societal gender expectations as contributing towards depression and hindering recovery, limiting their self-agency and ability to self-care.

### **Social support**

Four studies used quantitative research methods to investigate the role of social support in recovery from depression. An overall total of 5553 participants, 44.8% male and 55.2% female, participated in the included studies. Participants' ages ranged from 16 to 90 years. All of the studies used combinations of clinical interviews, researcher-developed questionnaires, or psychometric measures to assess a range of variables.

George et al. (1989) investigated associations between social support and the outcome of major depression. They found that size of social network and subjective social support were the most significant predictors of depressive symptoms at follow-up, with the exception of depression scores at baseline. Perceptions of inadequate social support generally predicted higher levels of depression. Impaired subjective social support was strongly associated with major depression, with stronger effects found for men more than women, and middle-aged adults more than older adults. However, this study's narrow inclusion criteria and recruitment of participants from a single inpatient facility limit the generalisability of findings. Furthermore, recovery from depression and social support were measured through self-report measures alone at follow-up, carrying potential for response bias.

Addressing these limitations, Brugha et al. (1990) investigated associations between initial levels of social support and recovery from depression. Participants were recruited following outpatient clinic attendances and completed a series of clinical interviews to measure both depression and social support. Higher numbers of close relationships, increased contact with members of social support networks, and increased satisfaction with support received, predicted clinical improvement and recovery from depression in women. In men, negative social interaction, living as married, and number of social contacts named as acquaintances or friends, predicted clinical improvement and recovery from depression. The differing perceptions of social support indicate that associations between personal relationships and recovery varied with gender.

Gladstone et al. (2007) also investigated perceptions of social support held by clinically depressed patients. They found that perceptions of low social support were

associated with objective markers of lifetime depression, particularly when family members were perceived as providing low social support. Lower perceived social support was also associated with greater depression symptomatology. Subjective reports further indicated that 51.2% of participants felt that lack of perceived social support posed complications for recovery from depression. Gladstone et al. suggest that recovery from depression might be facilitated by psychotherapeutic interventions that target development and maintenance of supportive relationships, and how to cope with interpersonal stressors. However, it must be noted that although this study demonstrates associations between perceived social support, depression symptomatology, and recovery from depression, it does not establish a causal relationship. It therefore remains unclear whether perceptions of social support are clouded by depression symptoms, or whether depression symptoms trigger erosion of social support networks over time.

To address the question of causation, Cruwys et al. (2013) investigated the role of social group memberships in alleviating depression symptoms, protecting against future depression and preventing depression relapse. They found that the number of social groups a person belongs to is a strong predictor of subsequent depression, with membership of fewer groups predicting greater levels of depression. The benefits of social group membership were found to be stronger amongst individuals who are depressed than those who are non-depressed, after controlling for confounding variables. Furthermore, proximal and distal analyses indicated that risk of depression relapse decreased by 24% in participants with depression who joined one social group (from zero), and by 63% if they joined three groups. Cruwys et al. conclude that social group membership is both protective against developing



depression, and facilitates recovery from depression by providing a ‘social cure’ for people already experiencing depression. However, generalisability of the study’s findings is limited by a sample that is predominantly white and aged over 50.

### *Summary of theme*

To summarise, higher levels of perceived social support and group memberships are shown to be associated with lower depression symptomatology and recovery from depression. Limited evidence indicates gender differences in perceptions of social support, although these have not been confirmed.

### **Patient and clinician perspectives**

Five studies investigated patients’ perspectives about what is important in recovering from depression, with one also investigating clinicians’ perspectives (Demyttenaere et al., 2015). Of these five studies, two used quantitative research methods (Brown et al., 2000; Demyttenaere et al., 2015), and three used qualitative methodology (Badger & Nolan, 2005; Johnson et al., 2009; van Grieken et al., 2014). An overall total of 1270 participants, 29.4% male and 70.6% female, participated in the included studies. Participants’ ages ranged from 18 to 75 years. All of the studies used combinations of clinical interviews, researcher-developed interview schedules, or psychometric measures to assess a range of variables.

Brown et al. (2000) investigated factors associated with symptomatic improvement and recovery from major depression in primary care patients. Lower depression symptom severity at eight months follow-up was associated with higher baseline functioning, minimal medical comorbidity, having an ethnicity reported as white, and receiving a standardised treatment (interpersonal psychotherapy or nortriptyline). Greater symptom reduction was experienced by individuals who both

perceived more self-control over their health and received standardised treatment. Furthermore, individuals who received a standardised treatment perceived greater levels of control over their health, and were more likely to recover from depression than those who received usual care. They also lacked lifetime generalised anxiety, panic, or personality disorder. In addition, analyses demonstrated that individuals in part- or full-time employment and with lower functional impairment at baseline were more likely to meet recovery criteria at follow-up. These results indicate that recovery from depression is influenced by factors such as health beliefs, non-depressive psychopathology, and higher levels of functioning, as well as clinical severity at baseline and adequacy of any treatments provided. However, the generalisability of the study's findings may be limited by the predominantly female sample.

Two studies examined accounts of recovery and perceptions of treatment amongst primary care patients (Badger & Nolan, 2005; van Grieken et al., 2014). Badger and Nolan found that recovery from depression was perceived as having multiple causes, including: social support, particularly from family members; medication and psychoeducation; responsive and caring practitioners; passage of time and timely interventions; and personal strength. As such, patients acknowledged the multi-factorial nature of recovery from depression, and accordingly expressed a preference for individualised components of care that change as recovery progresses. However, the authors' acknowledgement that the primary care practices involved in the study had an interest in mental health might suggest that results are not wholly generalisable to other practices and populations.

Consistent with findings from Badger and Nolan's (2005) study, patients interviewed by van Grieken et al. (2014) identified a range of treatment factors that

were perceived to impede their recovery from depression, based around four main themes: 1) lack of clarity and consensus about the nature of depression and the content of treatment; 2) precarious relationship with clinicians; 3) unavailability of mental health care; and 4) insufficient involvement of significant others, preventing full use of support networks. These themes are consistent with those identified by Badger and Nolan, particularly the benefits of information about treatment options, responsive and caring practitioners, and appropriate use of social support networks. As with Badger and Nolan's study, the generalisability of findings from van Grieken's research to other populations is hampered by a lack of range in participants' socio-demographic backgrounds.

Consistent with Badger and Nolan's (2005) findings, Johnson et al. (2009) found that the range of ways primary care patients with depression describe recovery indicates a need for more patient-centred approaches to setting goals for recovery from depression. Patients described assessing a person's recovery from depression on the basis of observation and human interaction, specifically their actions and interactions with others, their appearance, and their thoughts and feelings. However, some participants identified difficulty in assessing recovery amongst people who successfully hide their depression. Johnson et al. suggest that the indicators of recovery identified by participants contrast with more traditional symptom-based definitions of recovery.

Demyttenaere et al. (2015) compared physicians' and patients' perspectives of what is important in being 'cured' from depression. They found that perspectives differed significantly, with physicians focusing on alleviation of depression symptoms, and improvements in functioning and quality of life, and patients focusing on

restoration of positive affect (for example, having a meaningful and enjoyable life, ability to concentrate, personal strength, and satisfaction with personal relationships). Both physicians and patients consistently rated somatic symptoms as least important in being 'cured' from depression. Patients experiencing recurrent depression placed greater focus on restoration of positive affect than those patients experiencing a first episode of depression, and all patients placed greater focus on restoration of positive affect at three months follow-up. Demyttenaere et al. conclude that physicians and patients place importance on different factors when considering recovery from depression, carrying implications in terms of defining recovery from depression, and use of symptom-based depression measures. However, as this is the only study to investigate clinicians' perspectives of patient recovery from depression, replication is essential.

#### *Summary of theme*

To summarise, recovery from depression is influenced by a range of factors. These include health beliefs, non-depressive psychopathology, and higher levels of functioning, clinical severity at baseline, and treatment adequacy. The role played by support systems in facilitating recovery, including responsive and caring practitioners, was also emphasised. Patients described assessing a person's recovery from depression on the basis of observation and human interaction, and prioritise restoration of positive affect in recovery from depression. However, when assessing what is important in being 'cured' from depression, physicians' and patients' appear to prioritise different factors.

## Discussion

This paper synthesises the existing literature investigating perceptions of, and factors associated with, recovery from depression in adults. Throughout the literature, recovery from depression was perceived as a complex, personal journey. Normalised, biomedical, symptom-based definitions of recovery were not supported by patients (Emslie et al., 2005; O'Brien, 2012; Schreiber, 1996), with associations made between attempts to meet normative concepts of recovery and relapses into depression (Fullagar & O'Brien, 2014; O'Brien, 2012). Construction of the self, including self-care and self-agency, and management of societal gender expectations were identified as central features of recovery for women (Vidler, 2005).

Whilst Schreiber (1996) found that women's efforts to understand themselves and the world facilitated recovery from depression, O'Brien (2012) found that such efforts both impeded women's recovery and contributed to their depression. In particular, O'Brien found that women interpreted inability to return to previous normal functioning as failure to recover, compounded by societal gender expectations. The discrepancy between the two studies is potentially attributable to age differences between the women interviewed, with O'Brien focusing on women in mid-life (aged 35-49 years) and Schreiber focusing on women aged 32-69 years. It is possible that reports by women in O'Brien's study relating to the effects of societal gender expectations were concentrated to a greater extent than those in Schreiber's study, due to expectations relating to employment, motherhood, and marriage.

Recovery from depression was found to be associated with higher levels of perceived social support, and increased group memberships (Brugha et al., 1990; George et al., 1989; Gladstone et al., 2007). Social group membership was also

found to be protective against developing depression, and to facilitate recovery (Cruwys et al., 2013). Furthermore, responsive and caring practitioners were identified as contributing towards effective support systems and facilitating recovery (Badger & Nolan, 2005; van Grieken et al., 2014).

Recovery was further associated with a range of factors including health beliefs, non-depressive psychopathology, higher levels of baseline functioning, clinical severity at baseline, medication, and treatment adequacy (Badger & Nolan, 2005; Brown et al., 2000; van Grieken et al., 2014). Whilst patients prioritise restoration of positive affect in recovery from depression, physicians were found to prioritise alleviation of symptoms, and improvements in functioning and quality of life (Demyttenaere et al., 2015). Furthermore, patients describe assessing recovery from depression on the basis of observation and human interaction, as opposed to more traditional symptom-based definitions of recovery (Johnson et al., 2009).

### **Methodological critique**

Methodological weaknesses across the studies included in this review, including issues of generalisability and limited replication of findings, limit the strength of the conclusions drawn. The predominance of qualitative research methodology across the studies further limits both comparisons across studies and wider generalisation of findings, as focus is on participants' subjective experiences as opposed to objective measurement. Furthermore, the qualitative data analysis methods varied across the studies, again hindering direct comparison. Nevertheless, overarching themes did emerge across the existing literature (for example, recovery as a complex, multi-faceted process; the influence of social support networks; and

lack of support for normalised, symptom-based concepts of recovery), increasing the credibility of findings.

Across the studies included in this review, there was wide variation in sample sizes, ranging from 16 (Emslie et al., 2005) to 5055 (Cruwys et al., 2013). Whilst this in part reflects the diverse research methodology, the demographic of participants was characterised by a majority female sample (gender focus: 13.2% male and 86.8% female; social support focus: 44.8% male and 55.2% female; patient and clinician perspectives: 29.4% male and 70.6% female), lack of ethnic diversity, and recruitment solely within developed countries. It could be argued that the greater prevalence of depression amongst women than men across all age groups (Angst et al., 2002) warrants a greater proportion of female participants in recovery research. Nevertheless, the generalisability of findings beyond the demographic of participants included in the existing literature is limited.

A predominance of researcher-developed measures, particularly within the qualitative studies, further limits the ability to make cross-study comparisons. This predominance reflects the complexity of assessing and measuring perceptions of recovery. Furthermore, studies that employed standardised measures of depression used a range of measures, the quality of which was not assessed as part of this review. The range of measures used (both researcher-developed and standardised) potentially limits the ability to make comparisons between studies as assessment of depression severity or recovery is likely to vary.

Finally, one limitation of the QualSyst tool is that the checklists consist of items that the researchers perceive to represent research quality, defined in terms of internal study validity (Kmet et al., 2004). As such, the checklists do not assess the

psychometric properties of measures used in studies. The studies included in this review contained a range of depression measures and/or researcher-developed interview schedules. The quality and validity of these measures has therefore not been considered when assessing studies' research quality. The quality scores of included studies varied, such that findings from higher quality studies might outweigh findings from lower quality studies. However, differences in quality rating scores reflect the diversity of study designs and methodologies used. Furthermore, as mentioned above, all of the studies included in the review were assessed as having moderate to high quality.

### **Implications for clinical practice**

Despite the methodological weaknesses described above, the results of this review carry a range of implications for clinical practice. A key finding that clinicians working with adults experiencing depression should be aware of is that recovery from depression is a complex process, consisting of multiple facets (Badger & Nolan, 2005; Brown et al., 2000; Schreiber, 1996). Whilst clinicians tended to define recovery from depression in terms of alleviation of symptoms, and improvements in functioning and quality of life, patients focused more on restoration of positive affect (Demyttenaere et al., 2015). As such, clinicians should be aware that symptom-based definitions of recovery based on routine depression measures do not necessarily indicate recovery according to patient perspectives.

Clinicians should be aware of the potential impact of societal gender expectations in maintaining or exacerbating patients' depression, and of the positive associations between increased self-care, self-agency and recovery (Fullagar & O'Brien, 2014; Vidler, 2005). This is particularly the case in relation to patient-



practitioner relationships, with patients identifying practitioners who acknowledge patients' own roles in managing their depression and support individualised care as influential in assisting the recovery process (Badger & Nolan, 2005; van Grieken et al., 2014). As such, clinicians should consider routine use of patient-centred approaches to setting goals for recovery from depression (Johnson et al., 2009), and monitor the alliance between themselves and their patients to enable proactive identification and repair of potential ruptures.

The positive impact of social support and benefits of group membership in terms of protecting against, and assisting recovery from, depression should also be noted (Cruwys et al., 2013). Clinicians should therefore implement routine screening of patients' access to social groups, with a view to facilitating group membership amongst clients identified as having little or no access. Furthermore, clinicians should consider specific use of psychotherapeutic interventions to reduce the potential impact of depression on patients' perceptions of social support, facilitate social inclusion, and improve patients' ability to negotiate interpersonal challenges, such as cognitive-behavioural therapy (Beck, 1979) or interpersonal psychotherapy (Klerman et al., 1984).

### **Future research**

The findings from this review emphasise that recovery is a complex process, influenced by a range of factors. However, the findings themselves highlight specific gaps and methodological weaknesses within the existing literature. As such, a range of recommendations for future research can be made that would increase the credibility of the existing evidence base.

First, the existing literature uses a range of measures to assess depression

and recovery, hindering cross-study comparisons. Future researchers should endeavour to consider the psychometric properties and the content of measures used. This is due to the predominance of somatic, symptom-based items within these measures. Indeed, research indicates that these factors are not considered important by either physicians or patients in assessing recovery from depression (Demyttenaere et al., 2015). In response to such concerns, a new recovery measure named Recovering Quality of Life (ReQoL) has been co-produced with service users experiencing the broad spectrum of mental health difficulties, including depression (Keetharuth Brazier, Connell, Bjorner, Carlton, Taylor-Buck, et al., submitted).

Second, only one study conducted in-depth analysis of men's perceptions of recovery from depression (Emslie et al., 2005). Future research should therefore aim to further investigate men's perceptions of recovery from depression. As tentative gender differences also emerged regarding perceptions of social support (Brugha et al., 1990; George et al., 1989), replication of these findings would also be beneficial due to the potential for tailoring therapeutic interventions that target these perceptions.

Third, associations identified between client-practitioner relationships and recovery from depression warrant further investigation. In particular, replication of findings that recovery is facilitated by responsive and caring practitioners who recognise a role for individualised components of care (Badger & Nolan, 2005; van Grieken et al., 2014) could inform how care is delivered to this client group, with implications for enhancing recovery rates.

Finally, apparent differences emerged between physicians' and patients' perceptions of what is important in being in recovery from depression (Demyttenaere

et al., 2015). However, as it is not possible to conclude whether these differences were influenced by methodological factors (quantitative research methodology as opposed to qualitative methodology), replication of these findings is essential. Future research would benefit from in-depth comparison of physician and patient attitudes towards recovery from depression, to confirm the divergence of opinion and to inform clinical practice. Use of a mixed methods approach in future studies would enable confirmation of differences in perceptions through quantitative measures, complemented by in-depth qualitative analysis of both patients' and practitioners' perceptions of recovery from depression.

### **Conclusion**

On the basis of this review, we conclude that recovery from depression is perceived by patients as a complex, personal process that is influenced by a range of factors. However, greater understanding of clinicians' perceptions of client recovery from depression would be beneficial to inform clinical practice and influence future research.

### **Declaration of Interest**

The authors declare no conflicts of interests. The authors alone are responsible for the content and writing of this article.

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*Note.* Asterisk indicates papers included in the review.

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Table 1.

*Characteristics of studies included in review (see footnote for definitions of abbreviations)*

Author(s) and year	Study aims	Design and sample	Measures	Quality rating*
George, Blazer, Hughes, & Fowler (1989)	To investigate the effects of social support on the outcome of MD	Prospective design  150 inpatients (77 aged 35-50 years; 73 aged 60+ years)	<ul style="list-style-type: none"> <li>• CES-D</li> <li>• Duke Depression Evaluation Schedule for the Elderly</li> <li>• Duke Social Support Index (Landerman, George, Campbell, &amp; Blazer, 1989)</li> <li>• Clinical interview</li> </ul>	18/22 .82
Brugha, Bebbington, MacCarthy, Wykes, & Potter (1990)	To consider the relation between social support and recovery from depression	Prospective, cross-sectional design  130 patients attending outpatient and emergency clinics	<ul style="list-style-type: none"> <li>• Eysenck Personality Questionnaire (Eysenck &amp; Eysenck, 1975)</li> <li>• Clinical interview</li> <li>• Interview Measure of Social Relationships (Brugha et al., 1987)</li> </ul>	18/22 .82
Schreiber (1996)	To examine the process of recovery for women who have been depressed	Qualitative study  21 females; aged 32-69 years	<ul style="list-style-type: none"> <li>• Researcher-developed: semi-structured interview schedule</li> </ul>	16/20 .8

Author(s) and year	Study aims	Design and sample	Measures	Quality rating*
Brown, Schulberg, & Prigerson (2000)	To investigate factors associated with symptomatic improvement and recovery from MD in primary care patients	Experimental design  181 primary care patients	<ul style="list-style-type: none"> <li>• HRSD</li> <li>• Diagnostic Interview Schedule and SCID-II</li> <li>• Duke Severity of Illness Scale (Parkerson, Broadhead, &amp; Tse, 1993)</li> <li>• Global Assessment Scale (Endicott, Spitzer, Fleiss, &amp; Cohen, 1976)</li> <li>• Health Locus of Control Scale (Wallston, Wallston, Kaplan, &amp; Maides, 1976)</li> <li>• Psychiatric Epidemiology Research Interview (Dohrenwend, Askenasy, Krasnoff, &amp; Dohrenwend, 1978)</li> <li>• Interpersonal Support Evaluation List (Cohen, Mermelstein, Kamarck, &amp; Hoberman, 1985)</li> </ul>	21/26 .81
Badger & Nolan (2005)	To understand the factors to which primary care patients attribute recovery from depression	Qualitative study  60 primary care patients; aged 24-68 years	<ul style="list-style-type: none"> <li>• Researcher-developed: semi-structured interview schedule</li> </ul>	17/20 .85
Emslie, Ridge, Ziebland, & Hunt (2005)	To explore associations between depression and men's gender identities	Qualitative study  16 males; aged 30-75 years	<ul style="list-style-type: none"> <li>• Researcher-developed: semi-structured interview schedule</li> </ul>	18/20 .90
Vidler (2005)	To understand women's experience of depression	Qualitative study  22 females; aged 22-75 years (recruited from the Longitudinal Investigation of Depression Outcomes study)	<ul style="list-style-type: none"> <li>• Researcher-developed: semi-structured interview schedule</li> <li>• CES-D</li> </ul>	19/20 .95

Author(s) and year	Study aims	Design and sample	Measures	Quality rating*
Gladstone, Parker, Malhi, & Wilhelm (2007)	To investigate perceived multidimensional social support in adult patients with MD	Cross-sectional design  218 patients attending outpatient clinics	<ul style="list-style-type: none"> <li>• HDRS</li> <li>• Researcher-developed: self-report questionnaire assessing 'stressfulness' of life events and factors impacting on depression treatment</li> <li>• Beck Depression Inventory (Beck et al., 1961)</li> <li>• Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)</li> <li>• Clinical interview</li> </ul>	18/22 .82
Johnson, Gunn, & Kokanovic (2009)	To examine recovery from depression from patients' perspectives	Qualitative study  576 primary care patients; aged 18-75 years	<ul style="list-style-type: none"> <li>• Researcher-developed: structured interview schedule</li> <li>• CES-D</li> </ul>	15/20 .75
O'Brien (2012)	To critically examine mid-life women's recovery from depression	Qualitative study  31 females; aged 35-49 years	<ul style="list-style-type: none"> <li>• Researcher-developed: semi-structured interview schedule</li> </ul>	16/20 .80
Cruwys et al. (2013)	To investigate the effect of group memberships on depression symptomatology over time	Cross-sectional/longitudinal design  Adults enrolled in the English Longitudinal Study of Aging (proximal (N=5055) and distal (N=4087) samples)	<ul style="list-style-type: none"> <li>• CES-D</li> <li>• Single item question assessing group membership</li> </ul>	20/22 .91

Author(s) and year	Study aims	Design and sample	Measures	Quality rating*
Fullagar & O'Brien (2014)	To examine how women construct meaning about recovery from depression through self-care practices	Qualitative study 31 females; aged 35-49 years	<ul style="list-style-type: none"> <li>Researcher-developed: semi-structured interview schedule</li> </ul>	15/20 .75
van Grieken et al. (2014)	To explore patients' perspectives on how treatment can impede their recovery from depression	Qualitative study 27 patients; aged 22-63 years	<ul style="list-style-type: none"> <li>Researcher-developed: semi-structured interview schedule</li> <li>SCID-II</li> </ul>	16/20 .80
Demyttenaere et al. (2015)	Comparison of what physicians and patients consider important in being cured from depression	Cross-sectional design 426 primary and secondary care patients 118 physicians	<ul style="list-style-type: none"> <li>HDRS</li> <li>DEsCRIBE questionnaire</li> </ul>	17/20 .85

*Note.* CES-D = Centre for Epidemiologic Studies-Depression Scale (Radloff, 1977); HDRS = Hamilton Depression Rating Scale (Hamilton, 1967); HRSD = Hamilton Rating Scale-Depression (Hamilton, 1986); MD = major depression; SCID-II = Structured Clinical Interview for DSM-III-R Personality Disorders (Spitzer, Williams, Gibbon, & First, 1989).

\*Quality rating calculations for quantitative papers are calculated by dividing the total sum by the total possible sum; quality rating calculations for qualitative papers are calculated by dividing the total sum by 20 to obtain a summary score. Quality rating scores therefore range from 0 (minimum score) to 1 (maximum score), with exclusion of papers obtaining a quality rating score that is <.75.

Table 2.

*Overview of findings from reviewed studies (N = 14)*

Author(s) and year	Examined perceptions of:	Key findings
George, Blazer, Hughes, & Fowler (1989)	Secondary care patients	<ul style="list-style-type: none"> <li>• Size of social network and subjective social support were significant predictors of depressive symptoms at follow-up, with perceptions of inadequate social support generally predicting higher levels of depression.</li> <li>• Subjective social support was strongly associated with major depression, with a significantly stronger effect for middle-aged than older adults, and for men more than women.</li> </ul>
Brugha, Bebbington, MacCarthy, Wykes, & Potter (1990)	Outpatients	<ul style="list-style-type: none"> <li>• Higher levels of social support predict clinical improvement and recovery from depression.</li> <li>• Perceptions of social support differed between men and women, indicating that associations between personal relationships and recovery varied with gender.</li> </ul>
Schreiber (1996)	Community sample	<ul style="list-style-type: none"> <li>• The basic social psychological process of women's recovery from depression could be summarised as (re)defining the self.</li> <li>• (Re)defining the self considers the individual women and the social context in which their lives are situated, as opposed to more traditional conceptualisations of recovery that focus on symptoms.</li> </ul>
Brown, Schulberg, & Prigerson (2000)	Primary care patients	<ul style="list-style-type: none"> <li>• Lower depression symptom severity at eight months was associated with higher baseline functioning, minimal medical comorbidity, race and standardised treatment (interpersonal psychotherapy or nortriptyline).</li> <li>• Greater symptom reduction was experienced by individuals who both perceived more self-control over their health and received standardised treatment.</li> <li>• Individuals who received a standardised treatment perceived greater levels of control over their health, and were more likely to recover at eight months, than those who received usual care. They also lacked lifetime generalised anxiety or panic disorder.</li> </ul>



Author(s) and year	Examined perceptions of:	Key findings
Badger & Nolan (2005)	Primary care patients	<ul style="list-style-type: none"> <li>Recovery from depression was perceived as having multiple causes, including medication, passage of time, and personal strengths.</li> <li>Practitioners who recognised and acknowledged patients' roles in recovery and supported 'portfolios' of care were perceived as caring and offering individualised care that was holistic.</li> <li>Patients indicated a preference for components of care that changed as recovery progresses.</li> </ul>
Emslie, Ridge, Ziebland, & Hunt (2005)	Community sample	<ul style="list-style-type: none"> <li>As part of recovery from depression, men reconstructed a valued sense of themselves and their own masculinity, by incorporating values into narratives.</li> <li>A minority of men emphasised creativity, sensitivity, and intelligence, to redefine their 'difference' (i.e. depression) as a positive feature.</li> </ul>
Vidler (2005)	Community sample	<ul style="list-style-type: none"> <li>Relationships and social context were central to women's experience of depression.</li> <li>Recovery from depression was associated with increased self-caring and self-agency, and more active involvement in treatment decisions.</li> </ul>
Gladstone, Parker, Malhi, & Wilhelm (2007)	Outpatients	<ul style="list-style-type: none"> <li>Perceptions of low social support were associated with objective markers of lifetime depression.</li> <li>The role of interpersonal factors in maintaining depression indicates that psychotherapeutic interventions that target how to maintain or build supportive relationships, and how to cope with interpersonal stressors, might facilitate recovery.</li> </ul>
Johnson, Gunn, & Kokanovic (2009)	Primary care patients	<ul style="list-style-type: none"> <li>Patients' assessment of recovery from depression draws on observation and human interaction, leading to indicators of recovery that include traditional symptom-based definitions of recovery.</li> <li>The range of ways patients with depression describe recovery indicates a need for more patient-centred approaches to setting goals for recovery from depression in primary care settings.</li> </ul>
O'Brien (2012)	Community sample	<ul style="list-style-type: none"> <li>The 'recovery imperative' itself may be implicated in perpetuating cycles of recovery and relapse, by adding an additional burden to women's expectations of themselves.</li> </ul>

Author(s) and year	Examined perceptions of:	Key findings
Cruwys et al. (2013)	Community sample	<ul style="list-style-type: none"> <li>• The number of social groups that a person belongs to is a strong predictor of subsequent depression.</li> <li>• The benefits of social group membership are stronger among individuals who are depressed than those who are non-depressed.</li> <li>• Social group membership is protective against developing depression, and associated with recovery.</li> </ul>
Fullagar & O'Brien (2014)	Community sample	<ul style="list-style-type: none"> <li>• The process of recovery from depression was perceived as changing relations to the self.</li> <li>• Recovery constituted a generative process of caring for the self, and involved development of self-knowledge that valued 'being and doing' and capabilities.</li> <li>• Recovery discourses that focus on capability, rather than deficit, could contribute to more effective recovery oriented policies.</li> </ul>
van Grieken et al. (2014)	Community sample	<ul style="list-style-type: none"> <li>• Treatment factors identified as impeding recovery from depression yielded four main themes: 1) lack of clarity and consensus about the nature of depression and the content of treatment; 2) precarious relationship with clinicians; 3) unavailability of mental health care; and 4) insufficient involvement of significant others.</li> </ul>
Demyttenaere et al. (2015)	Primary & secondary care patients Physicians	<ul style="list-style-type: none"> <li>• Physicians' views of what is important in being cured from depression differ significantly from patients'.</li> <li>• Whilst physicians' focus is on alleviation of depressive symptoms, patients' focus is on restoration of positive affect.</li> </ul>

1. Initial session 'wants'
  - 1.1. Therapist-specific
    - 1.1.1. Managing expectations
    - 1.1.2. Alliance and rapport
  - 1.2. Client-specific
    - 1.2.1. 'Feeling better'
2. Defining 'recovery'
  - 2.1. Complexity
  - 2.2. Therapy-specific cues
  - 2.3. Service recovery
    - 2.3.1. Tension
  - 2.4. Clinical recovery
    - 2.4.1. Symptom changes/improved quality of life
    - 2.4.2. Self-reported changes
    - 2.4.3. Recovery journey
3. Meaning of 'recovery' to patients
  - 3.1. Patient benchmark: 'feeling better'
  - 3.2. Importance of recovery
    - 3.2.1. Symptom reduction
    - 3.2.2. Recovery 'buzz word'
4. Personal qualities beneficial for promoting recovery
  - 4.1. Therapist
    - 4.1.1. Awareness
    - 4.1.2. Empathy
    - 4.1.3. Flexibility
  - 4.2. Mutual
    - 4.2.1. Trust/faith
    - 4.2.2. Willingness
5. Barriers to recovery
  - 5.1. Lack of active engagement

*Figure 1. Final template*